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RESPONSE TO COVID-19/COMMENTARY

Restructuring the Peri-operative Pain Service to Palliative Care as a Response to the COVID-19 Pandemic

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Introduction

Modern-day management of patients with musculoskeletal disease benefits from a full peri-operative pain service. These services include pre-surgical screening, inpatient pain consultation, post-operative transition planning, and if needed post-operative follow-up for complex pain issues [5, 6]. At the Hospital for Special Surgery (HSS), this service is called the Peri-operative Pain Services (POPS) and is an extension of the Department of Anesthesiology, Critical Care, and Pain Management. The team consists of three full time physicians, all with a background in pain management and palliative care, six advanced practice providers (APPs), and two licensed clinical social workers (with additional staffing provided by anesthesia residents and fellows as needed). POPS averages about 1000 visits across all services per month.

Palliative care focuses on improving a patient's quality of life by managing pain and other distressing symptoms of serious illness. Palliative care teams work to match treatment choices with patients' goals, collaborating with patients, families, and other physicians to provide an extra layer of support. The Palliative Care Service at HSS was conceived in the Fall of 2016 and became active in January 2017. This team-based consultative service, with representation from medicine, anesthesia, social work, and spiritual care, performed five to ten consultations per year prior to 2019.

HSS Crisis Response

HSS leadership decided to stop all non-essential surgeries on Tuesday, March 17, 2020, 5 days before New York State required the cancelation of elective surgeries. Our partners at NewYork-Presbyterian Hospital (NYP) faced a significant challenge due to the surge of patients being admitted for acute respiratory distress syndrome related to infection with SARS-CoV-2, the virus that causes COVID-19. HSS alleviated their burden initially by accepting non-COVID-19 patients who needed further medical management. These included patients with pain issues such as sickle cell crisis and opioid tolerance. Some of these patients were transferred from NYPH on ventilator support to our critical care unit. Eventually, HSS received COVID-19 patients requiring ventilator support as well as supplemental oxygen support. HSS also opened an orthopedic triage center to divert emergent orthopedic cases from area hospitals. These cases included many patients with COVID-19, and more often than not complex medical comorbidities.

Peri-operative Pain Service Response

Stopping all non-essential surgeries and limiting in person visits significantly decreased the POPS volume. However, the influx of medically complex, critically ill patients increased the need for palliative care. The existing palliative care service was not set up to meet the demand created. The team-based consultative service required multiple members meet to see patients and come to consensus, but that prior process was far from ideal with social distancing measures in place and the higher volume and acuity of cases being referred.

For many reasons, the POPS team was the appropriate choice to assume the palliative role. Members of POPS were experienced in serving critically ill patients and had knowledge

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and comfort in managing pain with analgesics, treating symptoms to relieve suffering, and guiding discussions emphasizing shared decision-making. They were also used to partnering with many other medical and non-medical disciplines such as primary care, psychiatry, spiritual care, and nutrition. In addition, given the decreased surgical volume, members were available to help triage and support the palliative care service.

Operational Framework

The goal of the POPS in supporting the palliative care team was to continue to provide optimal pain management therapy to our patients and support our frontline colleagues. Seven-day-a-week coverage of the palliative care service was distributed across all available pain management physicians. The palliative consult was triaged by the covering provider. The consults varied in nature and severity, ranging from symptom management to determining goals of care or end of life care. When patients were deemed terminally ill, spiritual care was involved to support the families and staff as needed. Social work was called in to orchestrate support services to families.

As part of the pivot to palliative care a POPS physician or APP attended the daily huddles with the critical care team after the first intubated critical care COVID-19 patient was transferred from NYPH. As palliative care providers, team members updated the patients' family members with prognostic information and discussed goal-of-care decisions for their loved ones. Decisions regarding palliative/terminal extubation involved the entire medical team including consultation with our bioethics team. The number of palliative care consults in the month of April 2020 alone was four times that of the entire 2019 calendar year. The pre-existing palliative care service could have easily become overwhelmed. The use of pain management providers as palliative care providers enabled complex symptom management, decision-making advocacy and education, and a compassionate response to crisis management. Members of the POPS/palliative care team also educated staff members on health care proxies and advanced directives. The hospital's do-not-resuscitate (DNR) policies were updated to reflect the demands of the pandemic, and updates were distributed along with copies of the New York State Medical Orders for Life Sustaining Treatments (MOLSTs) to the inpatient units.

Creation of Family Medical Communications Team

The spread of COVID-19 changed the landscape of patient care. Following CDC guidelines, visitors were banned or limited in the hospital. The surge of COVID-19 patients admitted to our hospital had families who needed to be supported and to remain involved in health care decision-making. The formation of the Family Medical Communications Team (FMCT) by the Department of Anesthesiology, Critical Care, and Pain Management along with the Service Excellence Department added yet another layer of support. The goals of the FMCT were twofold: to provide support to patients and families and to allow the critical care team to focus on delivery of the highest quality care. The FMCT included a voluntary group of anesthesiologists and medical physicians, whose in-hospital work activities were curtailed due to postponement of elective surgeries. This service was coordinated by the clinical director for POPS. In addition, every attending physician in POPS was involved with the service, whether it was fulfilling the supporting role with the family or intervening as palliative care consultants. The physicians were able to access the electronic health record from home and take on the role of communicators between the intensivist taking care of the patient and the patient's family members. Service excellence was instrumental in determining the appropriate contact or surrogate decision maker. The communicator established a relationship with the patient's medical decision-maker and served as a liaison to the critical care team. The FMCT members provided a much-needed supportive role to patient families and to the critical care team.

Expansion of POPS Social Work Services

The POPS social workers assumed new roles as well. In addition to providing basic mental health support and grief counseling to family members, they assisted the attending physicians in helping families make difficult decisions regarding advanced directives. They also helped families navigate the logistics of dealing with a death in the age of COVID-19. Each family needed unique support, whether it was help with funeral arrangements or assistance getting family finances in order. The POPS social workers worked closely with the FMCT to provide constant support and established a bereavement program to support family members of patients who died at HSS.

The POPS social workers also took the lead in providing emotional support for the anesthesia department staff who were treating highly complex patients not seen in an orthopedic institution prior to this pandemic. Frontline staff were in unchartered waters, many unaccustomed to providing end-of-life care. In an effort to create a supportive environment, twice weekly Zoom support groups were set up for staff members to discuss their experiences, share tips, or air grievances. POPS social workers also recruited a group of individual psychotherapists that were made available to anesthesia staff to provide free one-on-one counseling sessions.

Implications for Future Operations

The COVID-19 pandemic created a unique working environment with a vital need for specialist palliative care [1]. We were fortunate to have access to pain management providers who were also palliative care certified. However, all pain management providers are well versed in challenging human connections, symptom management in pain, dyspnea, and delirium, with prior exposure to palliative care from residency and fellowship training [2, 4]. There was a quick learning curve to applying that knowledge, implementing existing resources, and updating protocols in response to the COVID-19 crisis [3].

In our institution, the need for palliative care resources lessened, yet we have remained prepared for a possible resurgence of COVID-19. We have the capability across all aspects of the HSS continuum to support compassionate communication, reduce suffering, and address burdensome symptoms for patients, their families, and frontline staff. We remain committed to providing the best possible care for all.

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Compliance with Ethical Standards

Conflict of Interest: Faye Rim, MD, Mary Kelly, FNP-BC, ONC, RN-C, Jefrey Meletio, LCSW, and Spencer Liu, MD, declare that they have no conflicts of interest.

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Required Author Forms Disclosure forms provided by the authors are available with the online version of this article.

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